

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, Georgia 30333

TYPHOID FEVER SURVEILLANCE REPORT



Instructions:

— Please complete this form only for new, symptomatic, culture-proven cases of typhoid fever. —

CDC NO.: (1-5)

Form Approved OMB No. 0920-0009

DEMOGRAPHIC DATA

1. Reporting State: <input type="text"/> <input type="text"/> (6-7)	2. First three letters of patient's last name: <input type="text"/> <input type="text"/> <input type="text"/> (8-10)	3. Date of birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (11-16) Mo. Day Yr. or Age: (in years) <input type="text"/> <input type="text"/> (17-18)
4. Sex: (19) 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	5. Does the patient work as a foodhandler? (20) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	6. Citizenship: (21) 1 <input type="checkbox"/> U.S. 0 <input type="checkbox"/> Other: _____ 9 <input type="checkbox"/> Unk.

CLINICAL DATA

7. Was the patient ill with typhoid fever? (fever, abdominal pain, headache, etc) (22) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, give date of onset of symptoms: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (23-28) Mo. Day Yr.	8. Was the patient hospitalized? (29) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, how many days was the patient hospitalized? <input type="text"/> <input type="text"/> <input type="text"/> (30-31) Days	9. Outcome of case: (32) 1 <input type="checkbox"/> Recovered 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unk.
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LABORATORY DATA

10. Date <i>Salmonella typhi</i> first isolated: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (33-38) Mo. Day Yr.	Site(s) of isolation: (check all that apply) (39) 1 <input type="checkbox"/> Blood 2 <input type="checkbox"/> Stool 3 <input type="checkbox"/> Gall bladder 4 <input type="checkbox"/> Other (specify): _____ (40-55)
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11. Was antibiotic sensitivity testing performed on this (these) isolate(s) at the laboratory? (Please contact the clinical laboratory for this information) (64) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, was the organism resistant to:	<ul style="list-style-type: none"> Ampicillin: (57) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not tested Chloramphenicol: (58) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not tested Trimethoprim-sulfamethoxazole: (59) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not tested Fluoroquinolones (e.g., Ciprofloxacin): (60) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Not tested
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EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? (two or more cases of typhoid fever associated by time and place) (61) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.					
13. Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness? (62) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, indicate type of vaccine received: <ul style="list-style-type: none"> Standard killed typhoid shot (Wyeth-Ayerst): (63) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (64-65) Oral Ty21a or Vivotif (Berna) four pill series: (66) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (67-68) ViCPS or Typhim Vi shot (Pasteur Merieux): (69) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (70-71) 				
14. Did the patient travel or live outside the United States during the 30 days before the illness began? (72) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States) <table border="0"> <tr> <td>1. _____ (73-88)</td> <td>3. _____ (105-120)</td> </tr> <tr> <td>2. _____ (89-104)</td> <td>4. _____ (121-136)</td> </tr> </table> Date of most recent return or entry to the United States: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (137-142) Mo. Day Yr.	1. _____ (73-88)	3. _____ (105-120)	2. _____ (89-104)	4. _____ (121-136)
1. _____ (73-88)	3. _____ (105-120)				
2. _____ (89-104)	4. _____ (121-136)				
15. Was the purpose of the international travel:					
a.) Business? (143) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. b.) Tourism? (144) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. c.) Visiting relatives or friends? (145) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	d.) Immigration to U.S.? (146) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. e.) Other? (147) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk. (If other, specify): _____ (148-164)				

16. Was the case traced to a typhoid carrier? (165) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.	If Yes, was the carrier previously known to the health department? (166) 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unk.
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17. Comments:

18. Name of Person Completing Form: _____
Address: _____
Telephone: (_____) _____ Date: _____ / _____ / _____ Mo. Day Yr.

— THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM —

Please send a copy to your STATE EPIDEMIOLOGY OFFICE and the
FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION,
Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205

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